COMMUNICABLE DISEASE CENTER

Morbidity and Mortality

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WEEKLY REPORT

Week Ending November 26, 1966

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE PUBLIC HEALTH SERVICE

EPIDEMIOLOGIC NOTES AND REPORTS
MEASLES – 1966

Oregon

An epidemic control program against measles in one Oregon Health Jurisdiction in the Portland area prompted two adjoining Jurisdictions to undertake similar programs for the protection of their children. This is one of the largest epidemic control measles immunization programs to date in the United States. Approximately 24,000 children from kindergarten through the third grades are to receive measles vaccine in the city of Portland, Washington County and Multonomah County during the 3-week program which began November 23, 1966.

Washington County, which has reported a total of 147 measles cases during the 4 weeks ending November 19 (MMWR, Vol. 15, Nos. 44-46), initiated the program. The neighboring Health Jurisdiction of Portland notified 5 cases for the week ending November 19. Thus, in order to abort the spreading epidemic, Portland and Multonomah County decided to participate in this cooperative effort.

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CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES
(Cumulative totals include revised and delayed reports through previous weeks)

DISEASE	47th WEEK ENDED		MEDIAN	CUMULATIVE, FIRST 47 WEEKS		
	NOVEMBER 26, 1966	NOVEMBER 27, 1965	1961–1965	1966	1965	MEDIAN 1961–1965
Aseptic meningitis	41	48	39	2,716	1,952	1,964
Brucellosis	1	6	8	212	223	354
Diphtheria	12	3	8	182	147	247
Encephalitis, primary:						
Arthropod-borne & unspecified	24	17	---	1,960	1,745	---
Encephalitis, post-infectious	9	10	---	666	610	---
Hepatitis, serum	30	575	776	1,309	30,424	39,085
Hepatitis, infectious	694			29,070		
Measles (rubeola)	950	1,414	2,316	196,372	250,745	401,998
Poliomyelitis, Total (including unspecified)	2	2	20	90	56	412
Paralytic	2	—	10	85	42	353
Nonparalytic	—	—	---	—	9	---
Meningococcal infections, Total	57	40	42	3,128	2,732	2,139
Civilian	46	39	---	2,825	2,538	---
Military	11	1	---	303	194	---
Rubella (German measles)	292	---	---	44,119	---	---
Streptococcal sore throat & Scarlet fever	8,263	6,806	6,548	376,578	350,395	304,044
Tetanus	4	7	---	175	252	---
Tularemia	1	2	---	160	230	---
Typhoid fever	2	13	11	347	407	491
Typhus, tick-borne (Rky. Mt. Spotted fever)	2	2	---	241	258	---
Rabies in Animals	57	51	64	3,663	3,902	3,436

NOTIFIABLE DISEASES OF LOW FREQUENCY

	Cum.		Cum.
Anthrax:	6	Botulism: Ind.-2	10
Leptospirosis: Tenn.-1	61	Trichinosis:	90
Malaria: Ky.-4, N.C.-8	440	Rabies in Man:	1
Psittacosis: Pa.-2, Mass.-1	44	Rubella, Congenital Syndrome:	21
Typhus, murine:	26	Plague:	5

MEASLES – 1966 *(Continued from front page)*

The program is sponsored by the three local Health Jurisdictions, the local medical societies, the school systems, and the Oregon State Board of Health.

(Reported by Dr. Edward Goldblatt, State Epidemiologist, Oregon State Board of Health.)

Snohomish County, Washington

A 3-day community-wide program to control an outbreak of measles in Snohomish County, Washington, was completed on November 30, 1966. Approximately 7,000 children from kindergarten through sixth grades were vaccinated. The urgency of this program was indicated by the 210 cases of measles reported during the 3-week period ending November 5, 1966 (MMWR, Vol. 15, Nos. 43-45). Emphasis was placed on availability of private physicians for immunization of younger children. The community program was conducted by the Snohomish County Health Department with support from the Snohomish County Medical Society, Washington State Department of Health, and the CDC.

(Reported by Dr. Earnest Ager, State Epidemiologist, Washington State Health Department.)

Kay County, Oklahoma

From September to November 18, 1966, 94 cases of measles were reported from Kay County, Oklahoma, most of which occurred in two of the county's four elementary schools. Approximately 600 children in the first through third grades were estimated to be susceptible. Preschool children and all susceptible school-age children in the four grammar schools were immunized in a vaccination campaign scheduled for November 28 and 29. Jet injector guns were used. A school surveillance system for measles is planned and the use of physician reporting improved so as to give an index of the success or failure of the immunization effort.

(Reported by Dr. LeRoy Carpenter, State Epidemiologist, Oklahoma State Department of Health.)

Rhode Island

On Sunday, January 23, 1966, the Rhode Island Medical Society and the Rhode Island Department of Health conducted the first Statewide END MEASLES campaign in which 33,853 children (67.2 percent of estimated susceptibles) were immunized. Another 2,589 children were vaccinated in the 39 follow-up clinics held through June 1966, thereby increasing the number immunized to 36,442 or 70 percent of estimated susceptibles.

An intensive surveillance system including case investigation has been instituted. All physicians have been reminded that measles is reportable to the State Department of Health within 24 hours of suspected diagnosis. School nurses, nursery school directors, and the district visiting nurses have all agreed to report suspected cases of measles in order that each case be investigated. In an effort to discover pockets of susceptibles, all Head Start programs are being contacted and military installations are encouraged to immunize dependent's children, many of whom have moved to Rhode Island since June. Plans are underway to include measles vaccine in the routine school immunization program.

The first confirmed case of measles since June was diagnosed during the week ending November 12 in an 8-year-old boy from Warren, Rhode Island, who had not been out of the state or had contact with another case of measles. The child had been immunized on END MEASLES Sunday in January and probably represents a case of vaccine failure. The child had not received gamma globulin either prior to or after the measles immunization.

Serological confirmation will be sought and a survey to determine measles susceptibility is to be undertaken in the child's school.

(Reported by Dr. Joseph E. Cannon, Director of Health, Rhode Island Department of Health; and an EIS Officer.)

CURRENT TRENDS

A total of 950 cases of measles was reported for the 47th week (ending November 26, 1966), a decrease of 209 cases from the total of the previous week and a decrease of 464 cases from the total of 1,414 reported for the 47th week of 1965. The three states reporting the highest number of cases for the 47th week are Texas with 196, Washington with 97, and Oregon with 96. Ten states reported no measles activity.

The 24 counties reporting 10 or more cases for the 46th week (ending November 19) are in 14 different states and are listed in Table 1; the geographic distribution of

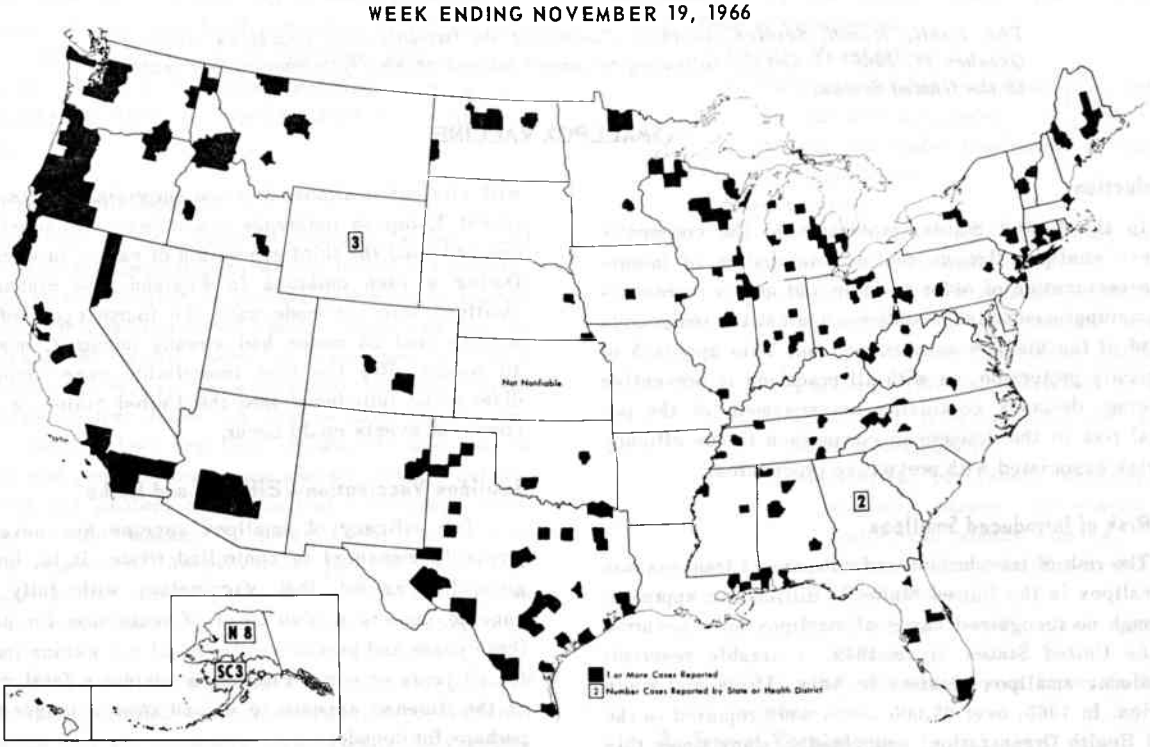
(Text continued on page 412)

Table 1
Counties Reporting Highest Number of Measles Cases
Week Ending November 19, 1966

County	State	Number of Cases
Snohomish*	Washington	89
Spokane	Washington	60
Oktibbeha	Mississippi	59
Washington*	Oregon	56
King	Washington	48
Durham	North Carolina	34
Allegheny*	Pennsylvania	27
Parker	Texas	27
Pueblo	Colorado	26
Douglas*	Oregon	25
Milwaukee	Wisconsin	24
Webster	West Virginia	23
Richardson	Nebraska	18
Brown	Texas	17
Ector	Texas	17
Menifee	Kentucky	15
Ward	North Dakota	15
Rutland*	Vermont	13
Bastrop	Texas	12
Galveston	Texas	12
Wood	Texas	12
Red River	Texas	11
Lamar	Texas	10
Alameda	California	10
Total		660

*Epidemic control measures or mass immunization programs have been instituted, are in progress, or are planned for the near future.

Figure 1
COUNTIES OR HEALTH DISTRICTS REPORTING MEASLES
WEEK ENDING NOVEMBER 19, 1966



SUMMARY OF REPORTED CASES OF INFECTIOUS SYPHILIS OCTOBER 1966 AND OCTOBER 1965

CASES OF PRIMARY AND SECONDARY SYPHILIS: By Reporting Areas October 1965 and October 1966 - Provisional Data

Reporting Area	October		Cumulative Jan - Oct	
	1966	1965	1966	1965
NEW ENGLAND	38	42	389	395
Maine	-	1	3	2
New Hampshire	2	2	10	25
Vermont	-	-	2	2
Massachusetts	23	31	268	240
Rhode Island	4	-	25	18
Connecticut	9	8	81	108
MIDDLE ATLANTIC	227	396	3,250	4,028
Upstate New York	26	54	304	469
New York City	86	199	1,949	2,318
Pa. (Excl. Phila.)	25	16	169	160
Philadelphia	25	38	227	262
New Jersey	65	89	601	819
EAST NORTH CENTRAL	327	289	2,732	2,538
Ohio	70	80	546	551
Indiana	6	6	80	47
Downstate Illinois	9	14	148	174
Chicago	102	94	883	1,011
Michigan	132	86	988	683
Wisconsin	8	9	87	72
WEST NORTH CENTRAL	39	56	351	449
Minnesota	6	9	30	78
Iowa	11	7	66	35
Missouri	13	25	127	199
North Dakota	-	-	4	2
South Dakota	-	4	27	38
Nebraska	5	5	42	72
Kansas	4	6	55	25
SOUTH ATLANTIC	492	683	5,203	5,706
Delaware	4	4	44	49
Maryland	57	59	473	393
District of Columbia	57	49	420	415
Virginia	25	15	265	274
West Virginia	6	21	60	78
North Carolina	59	93	741	861
South Carolina	63	70	744	701
Georgia	62	97	843	924
Florida	159	275	1,613	2,011

Reporting Area	October		Cumulative Jan - Oct	
	1966	1965	1966	1965
EAST SOUTH CENTRAL	184	163	1,943	2,269
Kentucky	15	10	119	120
Tennessee	28	26	257	438
Alabama	105	80	1,091	1,207
Mississippi	36	47	476	504
WEST SOUTH CENTRAL	267	201	2,308	1,989
Arkansas	17	14	135	187
Louisiana	62	58	544	581
Oklahoma	13	8	118	97
Texas	175	121	1,511	1,124
MOUNTAIN	53	36	373	463
Montana	2	3	30	14
Idaho	7	-	12	7
Wyoming	-	2	-	9
Colorado	2	6	36	44
New Mexico	14	9	87	95
Arizona	26	12	180	229
Utah	1	3	9	15
Nevada	1	1	19	50
PACIFIC	135	151	1,457	1,695
Washington	3	5	35	58
Oregon	1	6	39	33
California	126	136	1,348	1,570
Alaska	2	1	10	7
Hawaii	3	3	25	27
U. S. TOTAL	1,762	2,017	18,006	19,532
TERRITORIES	92	91	842	726
Puerto Rico	90	83	818	704
Virgin Islands	2	8	24	22

Note: Cumulative Totals include revised and delayed reports through previous months.

RECOMMENDATION OF THE PUBLIC HEALTH SERVICE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES

The Public Health Service Advisory Committee on Immunization Practices meeting on October 11, 1966, issued the following recommendations on smallpox vaccination practices in the United States.

SMALLPOX VACCINE

Introduction

In the United States, protection of the community against smallpox through routine vaccination of infants and revaccination of older children and adults represents the principal mechanism of defense against the indigenous spread of the disease once introduced. This approach to community protection, as with all practices in preventive medicine, demands continuing reassessment of the potential risk of the disease in comparison to the efficacy and risk associated with preventive procedures.

The Risk of Introduced Smallpox

The risk of introduction and subsequent transmission of smallpox in the United States is difficult to appraise. Although no recognized cases of smallpox have occurred in the United States since 1949, a sizable reservoir of endemic smallpox persists in Asia, Africa and South America. In 1965, over 63,000 cases were reported to the World Health Organization; undoubtedly, many times this number of cases occurred but were not recorded. A substantial proportion of smallpox cases are known to have occurred in urban centers.

Travel both by United States citizens and other nationals to and from smallpox endemic areas and this country is increasing annually. As seen recently in Europe, quarantine measures offer, at best, only partial protection against the introduction of smallpox. The traveler who has been vaccinated improperly or vaccinated with impotent vaccine or who bears a spurious vaccination certificate, is fully capable of developing the disease after passing quarantine inspection. Such, in fact, did occur in the United States as recently as 1962: A Canadian boy in apparently good health entered the United States through New York City from Brazil with a seemingly valid vaccination certificate. He developed smallpox after arriving in Canada less than 24 hours later.

In 75 instances during the past 18 years in which smallpox has been introduced into non-endemic areas, nationals of the country involved have been responsible for over three-fourths of the introductions. Should smallpox be introduced into the United States, it is similarly most probable that a United States citizen returning from abroad would serve to introduce the disease.

Smallpox, particularly variola major, remains a highly virulent disease even with excellent medical care. The mortality rate among unvaccinated persons was 40 percent in Sweden and in England during the outbreaks of 1962-63. Since few physicians in practice today are acquainted with clinical smallpox, it is not surprising that in several recent European outbreaks the disease remained unrecognized until the third generation of cases, or even later. During a 1966 outbreak in England, the diagnosis of smallpox was not made until the fourth cycle of transmission and 23 cases had already occurred, more than 10 weeks after the first identifiable case. Should the disease be introduced into the United States, a similar course of events could occur.

Smallpox Vaccination – Efficacy and Risks

The efficacy of smallpox vaccine has never been precisely measured in controlled trials. It is, however, generally agreed that vaccination with fully potent vaccine confers a high level of protection for at least three years and provides substantial but waning immunity for 10 years or more. Protection against a fatal outcome of the disease appears to extend over a longer period, perhaps for decades.

Smallpox vaccination, as with other medical procedures, is associated with a definite, measurable risk of morbidity and, rarely, death. A comprehensive national survey to ascertain the frequency of complications associated with vaccination in the United States during 1963 has recently been completed.[1] Among more than 6,000,000 primary vaccinees and nearly 8,000,000 revaccinees and their contacts, 12 cases of encephalitis following vaccination, 9 cases of vaccinia necrosum, and 108 cases of eczema vaccinatum occurred. Seven persons died. A substantial number of less serious complications, some of which resulted in hospitalization, were also recorded. All deaths and virtually all complications occurred among those vaccinated for the first time.

Furthermore, from these same data, it appeared that over half of the complications could have been prevented had contraindications to vaccination been more closely observed. Additionally, it was noted that complication rates were at least twice as high among children under one year of age as among other children.

If the routine practice of vaccinating infants and young children were to be terminated, consideration would need to be given to the consequence of the later primary vaccination of a large number of adults requiring protection by virtue of military service, travel abroad, or employment in medical or allied health professions. (Over half of all cases occurring following introduction of smallpox to non-endemic areas have been transmitted in the hospital setting.) It is estimated that these three

categories would involve between one and two million primary vaccinations annually.

Available data suggest that if primary vaccination were delayed until adulthood and administered to individuals faced with potential smallpox exposure, the number and seriousness of complications occurring each year would, in fact, be considerable greater than at present.

Other Prophylactic Agents

In recent years, Vaccinia Immune Globulin and certain antiviral compounds have been tested and reported by some to be effective in conferring protection against smallpox when administered shortly after exposure to the disease. At present, however, none appears to be a satisfactory alternative to vaccination. And most important, none confers protection lasting more than a few weeks. Thus, unless the first introduced case can be promptly and correctly diagnosed and all contacts quickly identified and treated, interruption of subsequent transmission of the disease by using these materials is virtually impossible. As previously pointed out, prompt diagnosis of the first introduced case has been the exception rather than the rule in recent European outbreaks.

Of added practical importance are the association of considerable gastrointestinal toxicity with the antiviral compounds and the critically short supply of Vaccinia Immune Globulin. In brief, therefore, none of these prophylactic agents is suitable for mass use at the time of a real or potential outbreak.

Conclusions and Recommendations

In recent years, international travel has increased substantially while the reservoir of endemic smallpox has changed but little. Correspondingly, the potential for the introduction of smallpox into the United States has, if anything, increased.

The 1966 World Health Assembly agreed to embark upon an intensive 10-year smallpox program. Based upon the effectiveness of vaccination campaigns in many of the developing countries, there is every reason to anticipate the success of this program. Eradication of endemic smallpox represents the most direct attack upon the problem and the only sure means for protecting the United States.

Until eradication is achieved or, at least, nears realization, vaccination, although not wholly without risk, clearly represents the only currently practicable approach for community protection in the United States. Considering the comparative risks of smallpox to the United States contrasted with the risks of vaccination, it is therefore important, at this time, to continue the present practice of widespread, routine smallpox vaccination in early childhood with subsequent revaccination.

Recommendations for Smallpox Vaccination

The following smallpox vaccination practices are recommended for the United States: (See Footnote*)

1. **Time of Vaccination**

   Primary Vaccination

   a. During the second year of life (i.e., between 1st. and 2nd. birthdays).
   b. At any age under conditions of exposure or foreign travel.

   Revaccination

   a. At time of entry into elementary school.
   b. At three-year intervals for:
      1) Persons who conceivably might be exposed in endemic or potentially endemic areas by virtue of international travel.
      2) Persons likely to be exposed by newly introduced infection into the United States, particularly:
         a) Hospital personnel, including physicians, nurses, attendants, laboratory and laundry workers.
         b) Other medical, public health, and allied professions.
         c) Morticians and other mortuary workers.
   c. At approximately 10-year intervals for all others.

2. **Site of Vaccination**

   On the skin over the insertion of the deltoid muscle or on the posterior aspect of the arm over the triceps muscle.

3. **Methods of Vaccination**

   Multiple Pressure Method[2]

   A small drop of vaccine is placed on the *dry*, cleansed skin and a series of pressures is made within an area about 1/8" in diameter with the side of a sharp, sterile needle held tangentially to the skin. The pressures are made with the side of the needle. For primary vaccination, 10 pressures are adequate; for revaccination, 30 pressures should be made. The remaining vaccine should be wiped off with dry, sterile gauze. Preferably, no dressing should be applied to the site.

   Other Vaccination Techniques

   Vaccination may be performed with other devices shown to be equally effective in assuring takes.

   Jet Injection Method

   Using vaccine specifically manufactured for this purpose, the recommended dose is inoculated intradermally with a jet injection apparatus. Excess vaccine should be wiped off with dry, sterile gauze. Preferably, no dressing should be applied to the site.

*All persons, regardless of age, entering the United States from non-exempt areas are required to be vaccinated or revaccinated within three years unless vaccination is medically contraindicated. The International Sanitary Regulations provide that "If a vaccinator is of the opinion that vaccination is contraindicated on medical grounds, he should provide the persons with written reasons underlying that opinion, which health authorities may take into account."[3]

4. **Interpretation of Responses***

The vaccination site should be inspected 6 to 8 days after vaccination. The response should be interpreted as follows:

Primary Vaccination

A primary vaccination which is successful should show a typical Jennerian vesicle. If none is observed, vaccination procedures should be checked and vaccination repeated with another lot of vaccine until a successful result is obtained.

Revaccination

Following revaccination, two responses are defined by the WHO Expert Committee on Smallpox eliminating use of older terms such as "accelerated" and "immune":[2]

a. **"Major reaction"**

A vesicular or pustular lesion or an area of definite palpable induration or congestion surrounding a central lesion which may be a crust or ulcer. This reaction indicates that virus multiplication has most likely taken place and that the revaccination is successful.

b. **"Equivocal reaction"**

Any other reaction should be regarded as equivocal. These responses may be the consequence of immunity adequate to suppress virus multiplication or may represent only allergic reactions to an inactive vaccine. If an equivocal reaction is observed, revaccination procedures should be checked and revaccination repeated with another lot of vaccine.

5. **Types of Vaccine**

Smallpox vaccine is presently available both in the glycerinated and the lyophilized form. Both forms, when properly preserved, afford excellent protection. The glycerinated form requires constant refrigeration at all stages in its transport and storage at temperatures recommended by the manufacturer. Comparatively minor storage difficulties may reduce its potency sufficiently to decrease efficacy in vaccination and particularly in revaccination. Even in excellent medical facilities, the glycerinated vaccine is often stored under improper conditions. Use of the much more stable lyophilized vaccine would insure more consistently effective vaccination. Due care must be exercised to provide proper handling of the lyophilized vaccine after reconstitution as described by the manufacturer.

6. **Contraindications to Vaccination**

a. Eczema and other forms of chronic dermatitis in the individual to be vaccinated *or in a household contact*. If vaccination is required for an individual with dermatitis because of potential exposure in an endemic area. Vaccinia Immune Globulin should be administered to the affected individual at the same time as the vaccine. If there is real need to vaccinate an individual who may create a hazard for a household contact with dermatitis, consideration should be given to separation of the vaccinee and his contact until a crust has developed.

b. Pregnancy. Vaccinia virus may, on occasion, cross the placental barrier during any stage of pregnancy and infect the fetus. Virtually all cases of fetal vaccinia have followed primary vaccination. If vaccination is indicated because of potential exposure in an endemic area, Vaccinia Immune Globulin should generally be given simultaneously with the vaccine, particularly if she is undergoing primary vaccination.

c. Patients with leukemia, lymphoma, and other reticuloendothelial malignancies or dysgamma globulinemia or those under therapy with immunosuppressive drugs such as steroid and antimetabolites or receiving ionizing radiation. If exposure should, by chance, occur, or if vaccination is absolutely essential, Vaccinia Immune Globulin should be administered.

7. **Vaccinia Immune Globulin (VIG)** (See Appendix)

a. Prophylaxis – 0.3 ml./kg. by the intramuscular route.

b. Treatment – 0.6 ml./.kg. by the intramuscular route:

1) In eczema vaccinatum, vaccinia necrosum or auto-inoculation vaccinia of the eye, VIG may be effective.

2) For severe cases of generalized vaccinia, VIG may be helpful in treatment. Such cases, however, almost invariably have a favorable outcome.

Note: For postvaccinal encephalitis, VIG is of *no* value.

8. **Thiosemicarbazones**

Certain of the thiosemicarbazone derivatives are reported by some to show a short-term protective effect against smallpox and possibly a therapeutic effect in individuals with severe vaccinal complications. These are experimental drugs and are not available for general use; their potential usefulness remains to be established.

*For purposes of validating certificates for international travel, primary vaccinations must be inspected. Although desirable, inspection of revaccinations is not mandatory.

REFERENCES

[1] Neff, John M., et al. Smallpox Vaccination Complications – United States – 1963. I. National Survey. II. Results Obtained by Four Statewide Surveys. To be published – New England Journal of Medicine.

[2] WHO Technical Report Series No. 283, WHO Expert Committee on Smallpox, 1964.

[3] International Sanitary Regulations, Article 98 (Footnote 9), World Health Organization, Geneva, 1966.

APPENDIX

Committee of American Red Cross Volunteer Consultants for the Distribution of Vaccinia Immune Globulin

VIG may be obtained within a few hours from any of the listed Regional Blood Centers of the American Red Cross following approval by a consultant

	Telephone	
	Office	Home
1. *Moses Grossman, M.D.* University of California San Francisco General Hospital (Ward 83) Room 334) San Francisco, California 94110	(415) 648-8200, Ext. 441	(415) 681-0475
Alternate: *Sidney Sussman, M.D.* (Same Address)	(Same)	(415) 564-8296
2. *Horace Hodes, M.D.* The Mount Sinai Hospital New York, New York 10029	(212) 876-1158, or 876-1000, Ext. 732 or 640	(516) 627-3691
Alternate: *Eugene Ainbender, M.D.* (Same Address)	(Same)	(914) 762-1148
3. *C. Henry Kempe, M.D.* University of Colorado School of Medicine 4200 East Ninth Avenue Denver, Colorado 80220	(303) 399-1211	(303) 322-4457
Alternate: *Vincent A. Fulginiti, M.D.* (Same Address)	(303) 399-1211, Ext. 7558	(303) 355-1032
Alternate: *Henry K. Silver, M.D.* (Same Address)	(303) 399-1211, Ext. 7558	(303) 355-7990
3. *James H. Pert, M.D.* The American National Red Cross Washington, D.C. 20006	(202) 857-3543 or 737-8300, Ext. 543	(301) 656-8375
Alternate: *Robert H. Parrott, M.D.* The Children's Hospital of the District of Columbia 2125 13th Street, N.W. Washington, D.C. 20009	(202) 387-4220, Ext. 280	(301) 365-0810
5. *Ralph V. Platou, M.D.* Tulane University School of Medicine 1430 Tulane Avenue New Orleans, Louisiana 70112	(504) 523-3381 Ext. 531	(504) 833-8301
Alternate: *Margaret H.D. Smith, M.D.* (Same Address)	(504) 523-3381, Ext. 380	(504) 861-4304
Alternate: *Norman C. Woody, M.D.* (Same Address)	(504) 523-3381, Ext. 531	(504) 899-9049
6. *Irving Schulman, M.D.* University of Illinois College of Medicine 840 Wood Street Chicago, Illinois 60612	(312) 663-6711	(312) 835-0160
Alternate: *Marvin Cornblath, M.D.* (Same Address)	(312) 663-6714	(312) 835-1774
7. *Paul F. Wehrle, M.D.* Los Angeles County General Hospital 1200 North State Street Los Angeles, California 90033	(213) 225-3115, Ext. 2231	(213) 287-9858
Alternate: *John M. Leedom, M.D.* (Same Address)	(213) 225-3115, Ext. 7285	(213) 288-1597
Alternate: *Allen W. Mathies, M.D.* (Same Address)	(213) 225-3115, Ext. 2231	(213) 799-7006
Distribution to the Armed Forces		
Edward L. Buescher, Lt. Col., M.C. Walter Reed Army Medical Center Washington, D.C. 20012	(202) 576-3757 or 723-1000, Ext. 3757	(301) 588-8835
Alternate: *Malcolm S. Artenstein, M.D.* (Same Address)	(202) 576-3478 or 723-1000, Ext. 3478	(301) 299-6211

CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES

FOR WEEKS ENDED

NOVEMBER 26, 1966 AND NOVEMBER 27, 1965 (47th WEEK)

AREA	ASEPTIC MENINGITIS		BRUCELLOSIS	ENCEPHALITIS			DIPHTHERIA		HEPATITIS		
				Primary including unsp. cases		Post-Infectious			Serum	Infectious including unsp. cases	Both Types
	1966	1965	1966	1966	1965	1966	1966	1965	1966	1966	1965
UNITED STATES...	41	48	1	24	17	9	12	3	30	694	575
NEW ENGLAND.....	1	2	-	1	1	-	-	-	-	48	27
Maine.....	1	-	-	-	-	-	-	-	-	11	5
New Hampshire.....	-	-	-	-	-	-	-	-	-	1	2
Vermont.....	-	-	-	-	-	-	-	-	-	-	1
Massachusetts.....	-	-	-	1	-	-	-	-	-	15	14
Rhode Island.....	-	2	-	-	-	-	-	-	-	11	1
Connecticut.....	-	-	-	-	1	-	-	-	-	10	4
MIDDLE ATLANTIC.....	15	5	-	5	3	1	1	-	12	101	87
New York City.....	1	-	-	1	2	-	1	-	9	17	26
New York, Up-State.	7	5	-	1	-	1	-	-	1	30	26
New Jersey.....	7	-	-	3	1	-	-	-	1	33	9
Pennsylvania.....	-	-	-	-	-	-	-	-	1	21	26
EAST NORTH CENTRAL...	3	8	-	3	2	-	-	1	1	103	129
Ohio.....	1	3	-	1	2	-	-	1	-	18	33
Indiana.....	-	1	-	1	-	-	-	-	-	11	11
Illinois.....	-	1	-	1	-	-	-	-	-	9	16
Michigan.....	1	3	-	-	-	-	-	-	1	55	60
Wisconsin.....	1	-	-	-	-	-	-	-	-	10	9
WEST NORTH CENTRAL...	2	4	1	3	-	1	-	1	-	29	10
Minnesota.....	2	4	-	2	-	1	-	-	-	1	2
Iowa.....	-	-	1	1	-	-	-	-	-	10	-
Missouri.....	-	-	-	-	-	-	-	-	-	16	2
North Dakota.....	-	-	-	-	-	-	-	-	-	-	1
South Dakota.....	-	-	-	-	-	-	-	1	-	-	-
Nebraska.....	-	-	-	-	-	-	-	-	-	-	1
Kansas.....	-	-	-	-	-	-	-	-	-	2	4
SOUTH ATLANTIC.....	4	3	-	3	-	1	3	1	2	144	45
Delaware.....	1	-	-	-	-	-	-	-	-	1	-
Maryland.....	-	-	-	2	-	-	-	-	1	16	6
Dist. of Columbia..	-	-	-	-	-	-	-	-	-	3	1
Virginia.....	-	1	-	1	-	-	-	-	-	9	21
West Virginia.....	-	-	-	-	-	-	-	-	-	4	4
North Carolina.....	-	-	-	-	-	-	-	-	1	6	3
South Carolina.....	-	-	-	-	-	-	-	1	-	-	2
Georgia.....	-	-	-	-	-	-	3	-	-	101	1
Florida.....	3	2	-	-	-	1	-	-	-	4	7
EAST SOUTH CENTRAL...	3	-	-	-	3	-	-	-	1	33	39
Kentucky.....	-	-	-	-	2	-	-	-	-	10	13
Tennessee.....	2	-	-	-	1	-	-	-	1	11	16
Alabama.....	1	-	-	-	-	-	-	-	-	5	5
Mississippi.....	-	-	-	-	-	-	-	-	-	7	5
WEST SOUTH CENTRAL...	-	1	-	1	1	-	4	-	2	25	31
Arkansas.....	-	-	-	-	-	-	-	-	-	2	7
Louisiana.....	-	-	-	1	1	-	3	-	2	4	6
Oklahoma.....	-	-	-	-	-	-	-	-	-	3	-
Texas.....	-	1	-	-	-	-	1	-	-	16	18
MOUNTAIN.....	-	3	-	-	4	-	-	-	-	50	33
Montana.....	-	-	-	-	-	-	-	-	-	3	5
Idaho.....	-	-	-	-	-	-	-	-	-	10	1
Wyoming.....	-	-	-	-	-	-	-	-	-	2	-
Colorado.....	-	-	-	-	-	-	-	-	-	5	11
New Mexico.....	-	-	-	-	-	-	-	-	-	20	6
Arizona.....	-	-	-	-	-	-	-	-	-	7	7
Utah.....	-	3	-	-	4	-	-	-	-	3	3
Nevada.....	-	-	-	-	-	-	-	-	-	-	-
PACIFIC.....	13	22	-	8	3	6	4	-	12	161	174
Washington.....	-	2	-	-	-	-	3	-	-	8	29
Oregon.....	-	-	-	2	-	-	-	-	-	37	6
California.....	13	20	-	6	3	6	1	-	12	114	127
Alaska.....	-	-	-	-	-	-	-	-	-	-	10
Hawaii.....	-	-	-	-	-	-	-	-	-	2	2
Puerto Rico.....	-	-	-	-	1	-	-	-	-	23	20

CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES

FOR WEEKS ENDED

NOVEMBER 26, 1966 AND NOVEMBER 27, 1965 (47th WEEK) - CONTINUED

AREA	MEASLES (Rubeola)			MENINGOCOCCAL INFECTIONS, TOTAL			POLIOMYELITIS				RUBELLA
							Total		Paralytic		
	1966	Cumulative		1966	Cumulative		1966	1965	1966	Cumulative	1966
		1966	1965		1966	1965				1966	
UNITED STATES...	950	196,372	250,745	57	3,128	2,732	2	2	2	85	292
NEW ENGLAND.....	18	2,491	37,145	3	144	142	-	-	-	-	44
Maine.....	6	274	2,899	-	12	18	-	-	-	-	9
New Hampshire.....	-	80	383	-	9	9	-	-	-	-	-
Vermont.....	1	317	1,375	-	4	8	-	-	-	-	-
Massachusetts.....	6	821	19,357	2	61	53	-	-	-	-	7
Rhode Island.....	-	73	3,951	-	17	16	-	-	-	-	1
Connecticut.....	5	926	9,180	1	41	38	-	-	-	-	27
MIDDLE ATLANTIC.....	49	18,348	16,222	16	404	364	-	-	-	-	15
New York City.....	4	8,354	2,870	2	64	59	-	-	-	-	8
New York, Up-State.	11	2,603	4,285	1	106	105	-	-	-	-	7
New Jersey.....	21	1,934	3,047	9	118	96	-	-	-	-	-
Pennsylvania.....	13	5,457	6,020	4	116	104	-	-	-	-	-
EAST NORTH CENTRAL...	143	69,831	58,798	4	493	413	-	-	-	7	81
Ohio.....	12	6,415	8,996	2	144	114	-	-	-	2	12
Indiana.....	8	5,782	2,187	-	85	47	-	-	-	1	5
Illinois.....	16	11,473	3,215	-	87	110	-	-	-	3	10
Michigan.....	44	14,924	27,157	-	127	95	-	-	-	1	19
Wisconsin.....	63	31,237	17,243	2	50	47	-	-	-	-	35
WEST NORTH CENTRAL...	26	9,039	17,111	3	161	134	-	-	-	1	13
Minnesota.....	4	1,669	759	-	35	32	-	-	-	1	-
Iowa.....	2	5,363	9,187	-	22	12	-	-	-	-	9
Missouri.....	-	537	2,638	2	63	53	-	-	-	-	-
North Dakota.....	12	1,274	3,950	-	11	12	-	-	-	-	4
South Dakota.....	-	40	115	-	5	3	-	-	-	-	-
Nebraska.....	8	156	462	-	9	10	-	-	-	-	-
Kansas.....	NN	NN	NN	1	16	12	-	-	-	-	-
SOUTH ATLANTIC.....	122	15,818	26,117	11	531	513	1	-	1	2	26
Delaware.....	-	262	509	-	5	10	-	-	-	-	1
Maryland.....	-	2,121	1,205	-	49	50	-	-	-	-	7
Dist. of Columbia..	-	388	94	-	14	11	-	-	-	-	-
Virginia.....	22	2,230	4,185	-	63	68	-	-	-	-	4
West Virginia.....	38	5,495	14,435	-	41	26	1	-	1	1	2
North Carolina.....	42	601	410	1	133	109	-	-	-	-	-
South Carolina.....	1	661	1,120	1	54	64	-	-	-	-	-
Georgia.....	2	240	626	9	77	60	-	-	-	1	-
Florida.....	17	3,820	3,533	-	95	115	-	-	-	-	12
EAST SOUTH CENTRAL...	71	20,168	14,826	2	269	208	-	-	-	4	28
Kentucky.....	4	4,777	3,010	2	95	79	-	-	-	-	19
Tennessee.....	52	12,540	8,324	-	92	67	-	-	-	-	9
Alabama.....	14	1,752	2,347	-	58	37	-	-	-	1	-
Mississippi.....	1	1,099	1,145	-	24	25	-	-	-	3	-
WEST SOUTH CENTRAL...	199	25,748	31,553	2	418	340	1	-	1	68	1
Arkansas.....	3	982	1,088	-	36	18	-	-	-	1	-
Louisiana.....	-	99	116	2	159	186	-	-	-	1	-
Oklahoma.....	-	538	226	-	21	21	-	-	-	1	-
Texas.....	196	24,129	30,123	-	202	115	1	-	1	65	1
MOUNTAIN.....	58	12,388	20,479	-	94	98	-	-	-	-	18
Montana.....	8	1,890	3,842	-	5	2	-	-	-	-	-
Idaho.....	7	1,671	2,963	-	5	13	-	-	-	-	7
Wyoming.....	2	219	858	-	6	5	-	-	-	-	-
Colorado.....	16	1,392	5,916	-	49	27	-	-	-	-	1
New Mexico.....	6	1,159	687	-	10	11	-	-	-	-	-
Arizona.....	10	5,345	1,398	-	13	20	-	-	-	-	5
Utah.....	9	657	4,601	-	1	17	-	-	-	-	5
Nevada.....	-	55	214	-	5	3	-	-	-	-	-
PACIFIC.....	264	22,541	28,494	16	614	520	-	2	-	3	66
Washington.....	97	4,536	7,433	4	48	41	-	-	-	2	35
Oregon.....	96	2,213	3,405	3	40	36	-	-	-	-	13
California.....	53	15,028	13,408	9	504	417	-	2	-	1	17
Alaska.....	14	606	203	-	18	18	-	-	-	-	1
Hawaii.....	4	158	4,045	-	4	8	-	-	-	-	-
Puerto Rico.....	55	3,285	2,759	-	16	11	-	-	-	1	1

CASES OF SPECIFIED NOTIFIABLE DISEASES: UNITED STATES
FOR WEEKS ENDED
NOVEMBER 26, 1966 AND NOVEMBER 27, 1965 (47th WEEK) - CONTINUED

AREA	STREPTOCOCCAL SORE THROAT & SCARLET FEVER	TETANUS		TULAREMIA		TYPHOID		TYPHUS FEVER TICK-BORNE (Rky. Mt. Spotted)		RABIES IN ANIMALS	
	1966	1966	Cum. 1966	1966	Cum. 1966	1966	Cum. 1966	1966	Cum. 1966	1966	Cum. 1966
UNITED STATES...	8,263	4	175	1	160	2	347	2	241	57	3,663
NEW ENGLAND.....	1,381	-	4	-	1	-	13	-	3	1	84
Maine.....	49	-	-	-	-	-	-	-	-	-	25
New Hampshire.....	15	-	-	-	-	-	-	-	-	1	29
Vermont.....	-	-	-	-	-	-	-	-	-	-	25
Massachusetts.....	167	-	2	-	1	-	9	-	1	-	4
Rhode Island.....	78	-	-	-	-	-	-	-	-	-	-
Connecticut.....	1,072	-	2	-	-	-	4	-	2	-	1
MIDDLE ATLANTIC.....	144	-	14	-	-	-	57	1	47	8	217
New York City.....	10	-	5	-	-	-	25	-	-	-	1
New York, Up-State.	122	-	2	-	-	-	12	-	13	5	200
New Jersey.....	NN	-	2	-	-	-	8	-	15	-	-
Pennsylvania.....	12	-	5	-	-	-	12	1	19	3	16
EAST NORTH CENTRAL...	1,157	-	20	-	20	1	42	-	19	2	470
Ohio.....	103	-	4	-	3	1	21	-	9	-	197
Indiana.....	110	-	4	-	10	-	4	-	-	2	109
Illinois.....	133	-	4	-	6	-	5	-	10	-	70
Michigan.....	228	-	6	-	-	-	6	-	-	-	41
Wisconsin.....	573	-	2	-	1	-	6	-	-	-	53
WEST NORTH CENTRAL...	476	-	15	-	19	-	33	-	4	18	838
Minnesota.....	10	-	3	-	1	-	1	-	-	5	200
Iowa.....	236	-	2	-	-	-	5	-	-	-	155
Missouri.....	7	-	8	-	10	-	17	-	3	3	244
North Dakota.....	147	-	-	-	-	-	1	-	-	1	49
South Dakota.....	17	-	-	-	4	-	-	-	-	6	103
Nebraska.....	1	-	1	-	2	-	2	-	-	3	26
Kansas.....	58	-	1	-	2	-	7	-	1	-	61
SOUTH ATLANTIC.....	870	1	33	-	12	1	67	1	110	9	467
Delaware.....	17	-	-	-	-	-	1	-	2	-	-
Maryland.....	71	-	3	-	2	1	12	-	26	-	3
Dist. of Columbia..	16	-	-	-	-	-	2	-	-	-	-
Virginia.....	272	-	6	-	2	-	16	-	31	4	238
West Virginia.....	288	-	-	-	1	-	1	-	-	2	56
North Carolina.....	29	-	4	-	3	-	6	-	27	-	4
South Carolina.....	22	-	2	-	1	-	13	-	5	-	-
Georgia.....	4	1	8	-	3	-	4	1	19	1	100
Florida.....	151	-	10	-	-	-	12	-	-	2	66
EAST SOUTH CENTRAL...	1,087	1	25	-	24	-	43	-	43	8	465
Kentucky.....	24	-	2	-	2	-	10	-	9	3	110
Tennessee.....	937	1	7	-	14	-	22	-	25	4	313
Alabama.....	95	-	8	-	4	-	6	-	7	-	20
Mississippi.....	31	-	8	-	4	-	5	-	2	1	22
WEST SOUTH CENTRAL...	481	-	42	1	72	-	34	-	10	10	728
Arkansas.....	1	-	4	1	55	-	4	-	2	-	80
Louisiana.....	-	-	10	-	4	-	10	-	-	1	50
Oklahoma.....	45	-	3	-	7	-	9	-	7	4	180
Texas.....	435	-	25	-	6	-	11	-	1	5	418
MOUNTAIN.....	1,021	-	2	-	9	-	17	-	4	-	95
Montana.....	37	-	-	-	2	-	-	-	-	-	7
Idaho.....	94	-	-	-	-	-	-	-	-	-	-
Wyoming.....	92	-	-	-	3	-	-	-	1	-	-
Colorado.....	388	-	2	-	-	-	4	-	2	-	18
New Mexico.....	241	-	-	-	1	-	2	-	1	-	16
Arizona.....	66	-	-	-	1	-	5	-	-	-	42
Utah.....	103	-	-	-	2	-	5	-	-	-	3
Nevada.....	-	-	-	-	-	-	1	-	-	-	9
PACIFIC.....	1,646	2	20	-	3	-	41	-	1	1	299
Washington.....	540	-	-	-	-	-	11	-	-	-	15
Oregon.....	46	-	1	-	-	-	1	-	-	-	4
California.....	1,011	2	19	-	3	-	27	-	1	1	280
Alaska.....	16	-	-	-	-	-	-	-	-	-	-
Hawaii.....	33	-	-	-	-	-	2	-	-	-	-
Puerto Rico.....	5	-	53	-	-	-	17	-	-	-	18

Week No. 47

DEATHS IN 122 UNITED STATES CITIES FOR WEEK ENDED NOVEMBER 26, 1966

(By place of occurrence and week of filing certificate. Excludes fetal deaths)

Area	All Causes		Pneumonia and Influenza All Ages	Under 1 year All Causes
	All Ages	65 years and over		
NEW ENGLAND:	706	419	32	34
Boston, Mass.	255	145	16	14
Bridgeport, Conn.	40	23	3	2
Cambridge, Mass.	23	14	1	-
Fall River, Mass.	26	13	-	1
Hartford, Conn.	54	32	2	4
Lowell, Mass.	35	25	2	-
Lynn, Mass.	13	11	1	-
New Bedford, Mass.	21	12	-	-
New Haven, Conn.	40	20	-	2
Providence, R. I.	66	37	-	2
Somerville, Mass.	12	7	1	1
Springfield, Mass.	47	28	2	3
Waterbury, Conn.	26	18	-	3
Worcester, Mass.	48	34	4	2
MIDDLE ATLANTIC:	3,041	1,743	114	118
Albany, N. Y.	50	29	1	2
Allentown, Pa.	35	20	1	-
Buffalo, N. Y.	129	67	3	5
Camden, N. J.	32	19	-	-
Elizabeth, N. J.	24	11	1	1
Erie, Pa.	33	16	3	2
Jersey City, N. J.	75	44	8	2
Newark, N. J.	62	31	4	6
New York City, N. Y.	1,593	917	56	65
Paterson, N. J.	45	23	2	4
Philadelphia, Pa.	490	274	7	13
Pittsburgh, Pa.	140	71	3	7
Reading, Pa.	32	26	3	-
Rochester, N. Y.	112	73	6	5
Schenectady, N. Y.	19	12	1	-
Scranton, Pa.	26	13	-	1
Syracuse, N. Y.	55	40	4	2
Trenton, N. J.	38	22	-	-
Utica, N. Y.	27	20	8	1
Yonkers, N. Y.	24	15	3	2
EAST NORTH CENTRAL:	2,271	1,263	75	104
Akron, Ohio	55	38	-	4
Canton, Ohio	25	11	-	1
Chicago, Ill.*	656	346	26	33
Cincinnati, Ohio	151	85	5	7
Cleveland, Ohio	170	79	2	4
Columbus, Ohio	110	57	2	2
Dayton, Ohio	84	48	-	3
Detroit, Mich.	295	161	5	17
Evansville, Ind.	39	26	4	2
Flint, Mich.	47	31	1	2
Fort Wayne, Ind.	27	18	3	1
Gary, Ind.	28	17	4	2
Grand Rapids, Mich.	44	28	1	1
Indianapolis, Ind.	124	67	5	7
Madison, Wis.	25	14	-	2
Milwaukee, Wis.	143	93	4	5
Peoria, Ill.	29	18	2	1
Rockford, Ill.	31	20	4	4
South Bend, Ind.	42	23	5	2
Toledo, Ohio	88	49	2	1
Youngstown, Ohio	58	34	-	3
WEST NORTH CENTRAL:	684	404	19	32
Des Moines, Iowa	39	27	-	1
Duluth, Minn.	18	15	-	1
Kansas City, Kans.	26	16	2	3
Kansas City, Mo.	124	71	2	4
Lincoln, Nebr.	17	11	-	-
Minneapolis, Minn.	89	50	2	-
Omaha, Nebr.	57	31	3	4
St. Louis, Mo.	216	122	6	14
St. Paul, Minn.	55	39	2	2
Wichita, Kans.	43	22	2	3
SOUTH ATLANTIC:	954	496	35	49
Atlanta, Ga.	115	45	3	14
Baltimore, Md.	198	104	5	12
Charlotte, N. C.	41	13	1	3
Jacksonville, Fla.	62	38	-	1
Miami, Fla.	58	34	-	-
Norfolk, Va.	44	17	1	4
Richmond, Va.	76	41	3	1
Savannah, Ga.	36	14	1	3
St. Petersburg, Fla.	47	38	4	1
Tampa, Fla.	73	48	6	4
Washington, D. C.	161	75	7	5
Wilmington, Del.	43	29	4	1
EAST SOUTH CENTRAL:	585	310	21	35
Birmingham, Ala.	66	31	-	5
Chattanooga, Tenn.	35	16	2	2
Knoxville, Tenn.	40	24	2	2
Louisville, Ky.	158	86	13	8
Memphis, Tenn.	137	72	2	7
Mobile, Ala.	23	12	-	2
Montgomery, Ala.	31	17	1	1
Nashville, Tenn.	95	52	1	8
WEST SOUTH CENTRAL:	919	466	32	94
Austin, Tex.	36	22	1	2
Baton Rouge, La.	19	12	3	1
Corpus Christi, Tex.	18	6	1	1
Dallas, Tex.	133	70	5	11
El Paso, Tex.	19	8	3	2
Fort Worth, Tex.	102	44	2	28
Houston, Tex.	139	66	5	13
Little Rock, Ark.	51	29	3	1
New Orleans, La.	188	89	2	17
Oklahoma City, Okla.	68	39	-	4
San Antonio, Tex.	77	41	1	10
Shreveport, La.	37	20	3	2
Tulsa, Okla.	32	20	3	2
MOUNTAIN:	394	228	8	16
Albuquerque, N. Mex.	36	17	3	3
Colorado Springs, Colo.	20	14	1	1
Denver, Colo.	100	57	-	4
Ogden, Utah	23	16	2	1
Phoenix, Ariz.	96	54	1	3
Pueblo, Colo.	22	16	-	-
Salt Lake City, Utah	41	23	-	1
Tucson, Ariz.	56	31	1	3
PACIFIC:	1,329	797	26	65
Berkeley, Calif.	15	12	-	-
Fresno, Calif.	36	20	-	1
Glendale, Calif.	26	19	2	2
Honolulu, Hawaii	32	13	1	2
Long Beach, Calif.	61	43	-	1
Los Angeles, Calif.	402	242	9	18
Oakland, Calif.	89	45	-	5
Pasadena, Calif.	32	24	-	1
Portland, Oreg.	69	43	1	7
Sacramento, Calif.	62	27	5	4
San Diego, Calif.	92	46	1	7
San Francisco, Calif.	152	93	2	5
San Jose, Calif.	42	26	4	3
Seattle, Wash.	129	82	1	5
Spokane, Wash.	46	34	-	1
Tacoma, Wash.	44	28	-	3
Total	10,883	6,126	362	546

*Estimate - based on average percent of divisional total.

Cumulative Totals
including reported corrections for previous weeks

All Causes, All Ages	586,640
All Causes, Age 65 and over	336,002
Pneumonia and Influenza, All Ages	24,075
All Causes, Under 1 Year of Age	31,301

MEASLES – 1966 *(Continued from page 402)*

counties and health districts reporting one or more cases of measles for the week is shown in Figure 1. This is the largest number of counties reporting 10 or more cases for one week so far in the 1966-67 epidemiological year. Snohomish and Spokane Counties in Washington notified 89 and 60 cases respectively, the highest numbers for the 46th week. Texas has the most counties reporting 10 or more cases.

(Reported by the Childhood Viral Diseases Unit, Epidemiology Branch, CDC.)

REVOCATION OF DIAGNOSIS
RABIES – Colorado

The original death certificate of an 11-year-old girl who died in Denver, Colorado, on April 2, 1966, stated that the cause of death was encephalitis, acute, rabies suspected (MMWR, Vol. 15, No. 16). The Laboratory of the Colorado State Department of Public Health had reported on April 3 that the fluorescent antibody test for rabies on brain tissue from the case was positive. Accordingly, an extensive rabies control program was conducted in the area where the case was believed to have been exposed.

Further laboratory studies were undertaken in the Colorado State Department of Public Health Laboratory and elsewhere. Mouse inoculation failed to reveal rabies virus. Therefore, the diagnosis has not been confirmed. On the death certificate, the cause of death has been corrected to "encephalopathy, acute, etiology undetermined." The case has been deleted from the cumulative total of human rabies cases in 1966.

(Reported by Dr. C.S. Mollohan, Chief, Epidemiology Section, Colorado State Department of Public Health.)

ERRATUM, Vol. 15, No. 45, p. 386

The following information was omitted in the article entitled "Salmonellosis Associated with Nonfat Dry Milk." The serotypes contaminating Starlac Instant Nonfat Dry Milk were *Salmonella binza* and *S. worthington*.

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IN ADDITION TO THE ESTABLISHED PROCEDURES FOR REPORTING MORBIDITY AND MORTALITY, THE COMMUNICABLE DISEASE CENTER WELCOMES ACCOUNTS OF INTERESTING OUTBREAKS OR CASE INVESTIGATIONS WHICH ARE OF CURRENT INTEREST TO HEALTH OFFICIALS AND WHICH ARE DIRECTLY RELATED TO THE CONTROL OF COMMUNICABLE DISEASES. SUCH COMMUNICATIONS SHOULD BE ADDRESSED TO:

THE EDITOR
MORBIDITY AND MORTALITY WEEKLY REPORT
COMMUNICABLE DISEASE CENTER
ATLANTA, GEORGIA 30333

NOTE: THE DATA IN THIS REPORT ARE PROVISIONAL AND ARE BASED ON WEEKLY TELEGRAMS TO THE CDC BY THE INDIVIDUAL STATE HEALTH DEPARTMENTS. THE REPORTING WEEK CONCLUDES ON SATURDAY; COMPILED DATA ON A NATIONAL BASIS ARE RELEASED ON THE SUCCEEDING FRIDAY.